

COMMONWEALTH OF VIRGINIA
Enforcement Division

Department of Health Professions
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463

www.dhp.virginia.gov

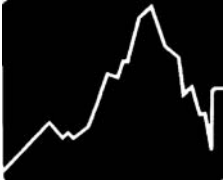
Phone (804) 367-4691
1-800-533-1560 VA Only
Fax (804) 527-4424

INSTRUCTIONS and CHECK LIST:

- Use a **SEPARATE** report form for each individual practitioner/licensee.
- Provide your contact information in the "Person Supplying Information" area.
- Provide the **name and contact information for the individual you are** reporting in the "Subject of Report" area.
- Provide a typed or legibly written description of your concern.** Attach additional pages to your report as needed.
- Provide important information such as the **dates and times** that the events occurred, **the names and contact information of all people** involved in your complaint, and the names and contact information for any witnesses. Use additional pages if necessary.
- Provide COPIES of documents regarding your report (*such as contracts, records, photographs, electronic media such as CD, DVD*). **NOTE: Documents submitted with the report cannot be returned.**
- Sign and date the report form (**Before signing, REVIEW THE NOTE BELOW about anonymity**)
- Make a copy of the report for your records.**
- Send the report by mail, fax, or email to:

Department of Health Professions
Enforcement Division
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463
Fax# 804-527-4424
Email: enfcomplaints@dhp.virginia.gov

NOTE: The Department of Health Professions cannot guarantee anonymity. Information regarding your report, including information provided by you, may be shared with the subject of the report (practitioner or licensee). If you wish to submit an anonymous report, do not include any information on the complaint form, envelope, email or supplemental documents that reveal your identity.



COMMONWEALTH OF VIRGINIA

Enforcement Division

Department of Health Professions
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463

www.dhp.virginia.gov

Phone (804) 367-4691
1-800-533-1560 VA Only
Fax (804) 527-4424

Office Use Only
Case Number

Date Received/PR

COMPLAINT FORM

PERSON SUPPLYING INFORMATION	NOTE: The Department of Health Professions cannot guarantee anonymity. Information regarding your report, including information provided by you, may be shared with the subject of the report (practitioner or licensee). If you wish to submit an anonymous report, do not include any information on the complaint form, envelope, email or supplemental documents that reveal your identity.			
	NAME (FIRST, MIDDLE, LAST)			HOME PHONE
	BUSINESS NAME (IF APPLICABLE)			WORK PHONE
	STREET ADDRESS			FAX NUMBER
	CITY/COUNTY	STATE	ZIP	EMAIL ADDRESS

SUBJECT OF REPORT (PRACTITIONER)	NAME (FIRST, MIDDLE, LAST)			TITLE/LICENSE TYPE
	BUSINESS NAME (IF APPLICABLE)			LICENSE NUMBER
	STREET ADDRESS			WORK PHONE
	CITY/COUNTY			HOME PHONE
	STATE	ZIP	EMAIL ADDRESS	

DETAILS OF REPORT

DETAILS OF REPORT	PLEASE PROVIDE SPECIFIC INFORMATION WHEN COMPLETING THE DETAILS REQUESTED BELOW. FAILURE TO PROVIDE SPECIFIC INFORMATION WILL LIMIT THE DEPARTMENT'S ABILITY TO INVESTIGATE YOUR CONCERNS.	
	PROVIDE THE FULL NAME (FIRST/LAST) AND CONTACT INFORMATION OF THE INDIVIDUAL (I.E. PATIENT/CLIENT) WHO RECEIVED SERVICES FROM THE PRACTITIONER.	
	WHAT IS YOUR RELATIONSHIP TO THE PRACTITIONER?	
	PATIENT/CLIENT <input type="checkbox"/> PATIENT/CLIENT'S RELATIVE/FRIEND <input type="checkbox"/> CO-WORKER <input type="checkbox"/> SUPERVISOR <input type="checkbox"/>	
	OTHER (SPECIFY:)	
	WHAT DID THE PRACTITIONER DO OR FAIL TO DO? INCLUDE SPECIFIC DETAILS: WHO, WHAT, WHERE, WHEN. ATTACH ADDITIONAL PAGES IF NECESSARY.	

Please continue on back of report

CONTINUED DETAILS OF REPORT

DETAILS OF REPORT	DID THE PATIENT/CLIENT SUSTAIN ANY INJURY OR HARM AS A RESULT OF THE LICENSEE'S ACTIONS? IF YES, PLEASE EXPLAIN.
	HAVE YOU CONTACTED THE LICENSEE REGARDING YOUR CONCERNS? IF YES, WHEN, AND DESCRIBE THE LICENSEE'S RESPONSE.
	IS YOUR CONCERN/ INCIDENT RELATED TO A FACILITY, PRIVATE OFFICE, HOME, ETC? PROVIDE SPECIFIC NAMES AND ADDRESSES OF EACH PLACE INVOLVED WITH THE CONCERN/INCIDENT.
	WHO ELSE HAS KNOWLEDGE OF THESE EVENTS? PROVIDE FULL NAMES AND CONTACT INFORMATION.
HAS YOUR COMPLAINT BEEN REPORTED TO ANY OTHER AGENCY OR COURT? IF SO, WHEN? PROVIDE THE NAMES, ADDRESSES, AND TELEPHONE NUMBERS OF THOSE CONTACTS.	

I WISH TO COMPLAIN ABOUT THE INDIVIDUAL/BUSINESS NAMED ABOVE. I UNDERSTAND THAT A REGULATORY BOARD DOES NOT HAVE THE AUTHORITY TO REQUIRE A LICENSEE TO RETURN MONEY OR PROVIDE OTHER PERSONAL REMEDIES. I FURTHER UNDERSTAND THAT DECISIONS REGARDING DISCIPLINARY ACTION OF LICENSEES ARE AT THE DISCRETION OF THE DEPARTMENT. I HAVE READ THE ABOVE AND HEREBY AFFIRM THAT THE INFORMATION SUBMITTED IS TRUE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE _____

DATE _____